

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/19/2026
NAME OF PROVIDER OR SUPPLIER  San Mateo Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE  222 West 39th Avenue San Mateo, CA 94403	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to thoroughly investigate an allegation of neglect for Resident 1, one of three sample residents. Resident 1 alleged she was calling out in pain for 4 hours and her call light was pulled out of the wall and was non-functional. The facility failed to: Interview other residents and/or responsible parties around Resident 1's room regarding call light response. Check to see if Resident 1's call light automatically triggers when pulled out of the wall socket. Ensure the Maintenance Director was knowledgeable regarding how a call light should function when unplugged from the wall. This failure may subject residents to delayed response to their request for assistance and may delay staff response to an emergent situation. Findings: During an interview on 2/12/2026 at 1:25 PM, Resident 1 stated .I believe it was sometime in January. I was sick really sick. I was in pain.I kept ringing for the nurse .nobody came to the room. Someone closed the door to the room .(later, I saw that my) call bell was not connected but.(initially) I didn't see that. I kept ringing and ringing .Nobody came so I was getting worried.I .(called the) hospital emergency room. (When the ambulance staff came to the facility and wheeled me out of my room, I saw) LVN 1 (License Vocational Nurse). sitting at the desk .I told her I was calling for hours for help. It was very scary. Review of Resident 1's medical record titled HOSPITAL DISCHARGE SUMMARY, dated 1/15/2026, indicated she was diagnosed with Recurrent acute diverticulitis (sudden onset of inflammation/infection of a portion of the colon= final section of the digestive tract, may cause sudden intense abdominal pain). During an interview on 2/13/2026 at 10:49 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated .(Resident 1 has a history) of false accusation. (Resident 1 will) use the call light but still yell for help.(Resident 1) will say that people are abusive to her .(because of this behavior,) we initiated a buddy system (when caring for her).(I think the incident happened in) 1/21/2026. She claimed she was in pain for 4 hours and called the ambulance. (but in reality) She never turned on the call light, she never called for help. Every time we checked, she was always asleep. She never screamed and yelled (for help). We were surprised. At 2:00 AM, I was charting and the ambulance came around 3:00 AM to take her to the hospital. LVN 1 stated this incident was investigated by her Unit Supervisor. During an interview on 2/13/2026 at 12:19 PM, the Unit Supervisor stated .she was transferred out on January 21. because of abdominal pain.it was included in my endorsement (shift to shift report). I'm not sure when she called me from the hospital. It wasn't documented. I remember she called. She was just complaining she was just transferred out. I did an investigation, nurses did their rounds and she was asleep. During their shift, nurses said .(Resident 1) never used her call light.(Resident 1) said she was in pain for 4 hours, no one came to help her. She used her call light, but she was unaware her call light was unplugged from the wall. During the interview the Unit supervisor stated:He did not document any of his investigation: he did not document interviews with the nurses, he did not document his interview with Resident 1. Therefore, he was unable to</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>accurately answer details about specific date, time and content of these interviews. He did not interview other residents, roommates, family members and/or responsible parties regarding this allegation. During a concurrent observation and interview with the Unit Supervisor on 2/18/2026 at 12:55 PM, Resident 1's call light in room [ROOM NUMBER] bed 1 was tested for its cord out call light feature. The cord out call light feature is designed to automatically trigger an alert/alarm at the nursing station when the call light is disconnected from the wall plug. When tested, the cord out feature of Resident 1's call light did not trigger an alert/alarm at the nursing station. During the interview, the Unit Supervisor stated he did not check to see if the cord out feature of Resident 1's call light was functioning during his investigation. Inspection of surrounding rooms found the cord out call light feature of rooms 205-1 and 204-2 not working. During an interview on 2/18/2026 at 1:10 PM the Maintenance Director stated he was not aware the facility's call light system had a cord out feature and his routine maintenance schedule does not include checking for/maintaining this feature of the call light system. Review of the facility's policy titled Abuse-Reporting &amp; Investigations, revised March 2018, indicated .The administrator or designated representative conducting the investigation will interview individuals who may have information relevant to the allegation . Individuals who may have information relevant to the allegation or suspected crime are the resident, witnesses to the incident, other residents under the care of the staff member involved, room mates, family, visitors, etc.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, facility staff failed to recognize and report an allegation of neglect for Resident 1, one of three sample residents: when Resident alleged she was in pain for four hours and staff failed to response to her call for assistance. This failure had the potential for residents to be subject to abuse/neglect. Findings: During an interview on 2/12/2026 at 1:25 PM, Resident 1 stated .I believe it was sometime in January. I was sick really sick. I was in pain. I kept ringing for the nurse .nobody came to the room. Someone closed the door to the room .(later, I saw that my) call bell was not connected but.(initially) I didn't see that. I kept ringing and ringing .Nobody came so I was getting worried. I .(called the) hospital emergency room. (When the ambulance staff came to the facility and wheeled me out of my room, I saw) LVN 1 (License Vocational Nurse). sitting at the desk .I told her I was calling for hours for help. It was very scary. Review of Resident 1's medical record titled HOSPITAL DISCHARGE SUMMARY, dated 1/15/2026, indicated she was diagnosed with Recurrent acute diverticulitis (sudden onset of inflammation/infection of a portion of the colon= final section of the digestive tract, may cause sudden intense abdominal pain). During an interview on 2/13/2026 at 10:49 AM, LVN 1 stated she was aware Resident 1 alleged she was in pain and staff did not response to her call for assistance. During an interview on 2/13/2026 at 12:19 PM, the Unit Supervisor stated he was aware Resident 1 alleged she was in pain and staff did not response to her call for assistance. During an interview on 2/19/26, 4:17 PM, the Director of Nursing stated when the Unit Supervisor talked to Resident 1 on the phone regarding her hospitalization on 1/21/2026, the Unit Supervisor did not identify Resident 1's allegation as an incident of neglect. The Unit Supervisor identified the allegation as Resident 1 just venting. Review of the facility's policy titled Abuse-Reporting &amp; Investigations, revised March 2018, indicated .The facility will report all allegations of abuse and criminal activity as required by law and regulations to the appropriate agencies. The Facility promptly reports and thoroughly investigates allegations of resident abuse, mistreatment, neglect, exploitation, abuse facilitated or enabled by the use of technology, misappropriation of resident property, or injuries of an unknown source, and suspicions of crimes.</p>		